TOWN OF WELLESLEY
HUMAN RESOURCES DEPARTMENT

PHYSICIANS RETURN TO WORK RECOMMENDATION FORM

Employee's Name: Date:

Physician's Name: Telephone #:

To be completed by Physician:
After reviewing the attached job description and the specific tasks within the job description please complete either (A) or (B) or (C) as appropriate and sign and date below:

☐(A) The above named employee has been released by the above named physician to return to full duty as of _____(Date) **WITH NO RESTRICTIONS**.

☐(B) The above named employee has been released by the above named physician to return to work on _____(Date) **WITH THE FOLLOWING RESTRICTIONS** through _____(Date - unknown will not be accepted).

☐(C) The above named employee has **NOT** been released by the above named physician to return to work at this time. Follow up appointment is scheduled for _____(Date - unknown will not be accepted).

Check applicable boxes and provide limitations/restrictions:

☐ Lifting (Max weight in lbs)	_____lbs.	☐ Walking	_____ hours per day
☐ Repetitive Lifting	_____lbs.	☐ Standing	_____ hours per day
☐ Carrying	_____lbs.	☐ Sitting	_____ hours per day
☐ Pushing/Pulling	_____lbs.	☐ Crawling	_____ hours per day
☐ Pinching/Gripping	_____lbs.	☐ Kneeling	_____ hours per day
☐ Reaching over head		☐ Squatting	_____ hours per day
☐ Reaching away from body		☐ Climbing	_____ hours per day

☐ Repetitive Motion Restrictions:

☐ Other Restrictions:

These limitations/restrictions are:
☐ Temporary limitations/restrictions expected to last until _____(Date)
☐ Permanent limitations/restrictions

If you have questions or need additional information regarding the employee's essential job functions, please contact the Workers' Compensation Coordinator at (781) 431-1019 x2236.

My signature indicates that I have **read and understand** the employee's job description and the listed tasks within the job description and that my findings are based on my medical assessment of this employee's physical capabilities as compared to the essential functions of the job.

Physician's Name (Please Print):

Physician's Signature: Date:

I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

Employee's Signature: Date:

Please return completed form to: Jen Glover, Workers Comp Coordinator, jglover@wellesleyma.gov F: 781.431.8643